MEDICARE HOSPITAL VALUE-BASED PURCHASING (VBP) (Sec. 3001 PPACA)

The law establishes a VBP program to pay hospitals for their actual performance on quality measures, rather than just the reporting of those measures, beginning in FY 2013. The VBP program will apply to all acute-care prospective payment system (PPS) hospitals. Certain hospitals are excluded, including those that do not have a sufficient number of patients within the related conditions. A demonstration project will be created for critical access hospitals (CAHs).

Measures will be selected from those used in the Medicare pay-for-reporting program, including measures for heart attack, heart failure, pneumonia and surgical care, and measures assessing patients' perception of care (HCAHPS). The VBP program is restricted from including readmission measures. The HHS Secretary is directed to include measures of healthcare-associated infections. The Secretary is mandated to include measures assessing efficiency, including measures of Medicare spending per beneficiary, which will be adjusted for differences in age, sex, race, severity of illness and other factors, as determined by the Secretary, in FY 2014 and beyond. Selected quality measures will need to be considered by a consensus-based organization, such as the National Quality Forum (NQF), although the Secretary will have discretion to implement other measures under certain circumstances.

Funding for the program will be generated by reducing all Medicare inpatient PPS Medicare-severity DRG (MS-DRG) payments to participating hospitals using a phased-in approach. Payments will be reduced by 1 percent in FY 2013; 1.25 percent in FY 2014; 1.5 percent in FY 2015; 1.75 percent in FY 2016; and 2 percent in FY 2017 and beyond. The reduction will be applied to all MS-DRGs but will not affect disproportionate share, indirect medical education, low-volume adjustment or outlier payments. A hospital will be rewarded for quality improvement or quality attainment, whichever level is higher.

A methodology for assessing hospital performance will be developed by the Secretary; a hospital that meets or exceeds the performance standards will be eligible to earn back the initially withheld money. A hospital's total composite performance score will be calculated and used to determine whether the hospital meets the overall performance standard. The payment adjustment will apply only to the relevant fiscal year, based on the prior year's performance, and will not be taken into account in calculating payments in future fiscal years. The program will be budget-neutral; that is, all of the money withheld to fund each year's incentive payments will be returned to hospitals.

In order to track the progress of the VBP program, the Government Accountability Organization (GAO) shall submit an interim report to Congress by October 1, 2015. The Secretary shall submit a report to Congress by January 1, 2016. The GAO shall submit a final report to Congress by October 1, 2017.

Two demonstration projects will be created to test VBP models for CAHs and small hospitals that do not qualify, due to an insufficient number of qualifying cases, for the VBP program. These demonstration projects shall be implemented by March 23, 2012 (two years after

enactment) and completed by March 23, 2015. The Secretary shall submit a report to Congress by September 23, 2016 (18 months after the end of demonstration).

MEDICARE VBP: SNFs, HHAs, ASCs (Sec. 3006 PPACA)

The legislation directs the Secretary to submit to Congress implementation plans for VBP programs for SNFs and HHAs by October 1, 2011, and for ASCs by January 1, 2011. These plans will be created in consultation with stakeholders and will address the development, measurement and modification of quality and efficiency measures; the reporting, collection and validation of quality data; the structure of proposed value based payment adjustments; criteria for both reductions and incentives and methods for public dissemination. The Secretary will consider experiences with demonstrations that are relevant to VBP in each setting.

PILOT VBP: OTHER MEDICARE PROVIDERS (Sec. 10326, PPACA)

The law requires the HHS Secretary, by January 1, 2016, to conduct VBP pilot programs for psychiatric hospitals and units, LTCHs, IRFs, PPS-exempt cancer hospitals and hospice programs. Further, no earlier than January 1, 2018, the Secretary may expand the duration and scope of these VBP pilot programs based on whether Medicare spending is reduced, quality is maintained or increased, and coverage or beneficiary benefits are not limited or denied.

MEDICARE PHYSICIAN VBP (Sec. 3007, PPACA)

The law institutes a budget-neutral VBP adjustment to the physician fee schedule by directing the HHS Secretary to evaluate physicians' quality of care compared to cost and apply a payment modifier under the physician fee schedule based on the evaluation. The Secretary is required to publish specific measures of quality and cost by January 1, 2012. The implementation of the modifier will begin during the 2013 rulemaking process and an initial performance period will begin in 2014. The payment change will be implemented beginning in 2015 for specific physicians and groups of physicians, as determined by the Secretary, and will expand to all physicians and groups of physicians in 2017, including other eligible health care practitioners, as determined by the Secretary.

APPENDIX A

Year-by-Year Payment Changes Affecting Annual Updates for Inpatient PPS Hospitals

Inpatient Prospective Payment System (IPPS) Policy	Fiscal Year									
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Market Basket (MB) Cuts for Productivity Adjustment (P)[1] and Medicare Savings	MB – 0.25	MB – 0.25	MB – (P + 0.1)	MB – (P + 0.1)	MB – (P + 0.3)	MB – (P + 0.2)	MB – (P + 0.2)	MB – (P + 0.75)	MB – (P + 0.75)	MB – (P + 0.75)
Reporting Hospital Quality Data for the Annual Payment Update[2] (Pay for reporting)	MB – 2.0 If Failure to Report	MB – 2.0 If Failure to Report	MB – 2.0 If Failure to Report	MB – 2.0 If Failure to Report	MB – 2.0 If Failure to Report	MB – ¼ of MB If Failure to Report	MB – ¼ of MB If Failure to Report	MB – ¼ of MB If Failure to Report	MB – ¼ of MB If Failure to Report	MB – ¼ of MB If Failure to Report
Hospital Value-Based Purchasing[3]				MB – 1.0 Potential for Earn Back	MB – 1.25 Potential for Earn Back	MB – 1.5 Potential for Earn Back	MB – 1.75 Potential for Earn Back	MB – 2.0 Potential for Earn Back	MB – 2.0 Potential for Earn Back	MB – 2.0 Potential for Earn Back
Readmissions[4]				MB – Hosp-specific amount capped at 1.0	MB – Hosp-specific amount capped at 2.0	MB – Hosp-specific amount capped at 3.0	MB – Hosp-specific amount capped at 3.0	MB – Hosp-specific amount capped at 3.0	MB – Hosp-specific amount capped at 3.0	MB – Hosp-specific amount capped at 3.0
Hospital Acquired Conditions						MB – 1.0 For Bottom Quartile Hospitals	MB – 1.0 For Bottom Quartile Hospitals	MB – 1.0 For Bottom Quartile Hospitals	MB – 1.0 For Bottom Quartile Hospitals	MB – 1.0 For Bottom Quartile Hospitals
Health Information Technology Meaningful Use[5] (MU)						MB – ¼ of MB If Failure to Meet MU	MB – ½ of MB If Failure to Meet MU	MB – ¾ of MB If Failure to Meet MU	MB – ¾ of MB If Failure to Meet MU	MB – ¾ of MB If Failure to Meet MU

Note: all numeric reductions represent a percentage point reduction from the market basket rate. For example if the market basket is projected to be 3% and the reduction is 2 percentage points, then the remaining amount for the update is 1%.

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[1] The productivity adjustment (P) is the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity, as projected by the Secretary. The productivity adjustment is permanent, extending beyond the 10-year budget window of the law.

[2] Hospital quality reporting requirements tied to the update were enacted by the Medicare Modernization Act of 2003. The American Recovery and Reinvestment Act (ARRA) of 2009 modified the reduction when penalties for not meeting "meaningful use" of electronic health record adoption were enacted.

[3] VBP is funded by a reduction in the update, growing from 1 percentage point in 2013 to 2 percentage points in 2017 and beyond. The potential for "earn back" derives from these reductions and will be based on individual hospital performance. The VBP is budget neutral.

[4] If a hospitals' readmission rate is higher than expected, the hospital's update is reduced by a hospital-specific amount, not to exceed 1 percentage point in 2013 and not to exceed 3 percentage points in 2016 and beyond.

[5] The ARRA requires hospitals to become "meaningful users" of electronic health records in order to avoid update reductions.

IHA Federal Legislative Position 2009
Medicare Value-Based Purchasing

⋆ Overview

Policymakers and those in the health care industry have been taking steps toward making the Medicare program a purchaser of value, beginning in 2003 when Congress linked Medicare payments to the reporting of quality measures. As required by the Deficit Reduction Act of 2005 (DRA), the Centers for Medicare & Medicaid Services (CMS) submitted a plan to Congress on implementing a Medicare value-based purchasing (VBP) program for hospitals. Since the submission of this plan in 2007, legislation has been passed expanding the number of quality reporting measures and increasing the payment penalty for those hospitals choosing not to participate in the quality reporting program. Measures and payment update factors have been expanded to include hospital outpatient services, with payment penalties beginning in 2009 for hospitals electing not to report the outpatient indicators. Most recently, VBP legislation has been introduced in the United States House of Representatives, and Senators Grassley and Baucus on the Senate Finance Committee have released a bipartisan discussion draft of VBP legislation.

⋆ Iowa Hospital Association Position

Iowa hospitals are leading the way in providing high-quality, low-cost health care. The 2008 Dartmouth Atlas Project ranked Iowa first in the nation for health care system efficiency, concluding that the state should serve as a model for the country. Dartmouth found that Medicare spent an average of $39,243 per chronically ill patient for end-of-life care in Iowa, the lowest in the nation and more than 30 percent below the national average of $52,838. The 2007 Commonwealth Fund report, "Aiming Higher; Results from a State Scorecard on Health System Performance," underscores Iowa hospitals' commitment to ensuring Iowans continue to receive high-quality, low-cost health care. The report ranks Iowa second in the nation across key dimensions of health system performance. Iowa was the only state to rank in the top quartile across all five assessments: access, quality, avoidable hospital use and costs, equity and healthy lives.

IHA continues to support the Medicare program becoming a purchaser of value. Any attempt, however, to move toward a value-based payment system must include measures for enhancing the efficiency of health care delivery. In addition, the Medicare Payment Advisory Commission (MedPAC) has commented that "efficiency measures should be included in the hospital VBP program as soon as possible," and that it "believes that a P4P program will be incomplete until it includes measures of both quality and provider resource use." Private industry, through the Leapfrog Group, states that "efficiency is an attribute of performance that examines the relationship between a specific output of the healthcare system (e.g., a quality outcome for a patient) and the resources needed to create that output (e.g., costs)." A Medicare VBP program must include both quality and efficiency benchmarks when evaluating and rewarding hospital

performance. The failure to include an efficiency factor in moving Medicare to a VBP methodology will continue to promote outcome disparities for recipients. A Medicare VBP program should create a more rational payment methodology and move away from some of the well-recognized inadequacies of the current payment system.

A VBP program should also:

- **Align incentives among hospitals, physicians and other providers.** Aligning incentives across hospitals, physicians, and other providers will help create the efficient delivery of care as well as encourage the coordination of care. As exemplified across the country, hospitals and physicians are willing to engage in partnerships that improve outcomes for care. Examples of this include Iowa's development of the Iowa Healthcare Collaborative (IHC), a provider-led nonprofit organization that works toward the goal of higher quality of care by aligning hospitals and physicians, promoting responsible public reporting, engaging the community for clinical improvement, and raising the standard of care in Iowa.

- **Provide incentives to encourage care coordination.** The fragmentation of the delivery of health care in the Medicare system creates overutilization and a VBP program should provide incentives to encourage care coordination. In the State of Iowa, progress is being made through legislation and changes in physician practices involving the concept of a medical home. A medical home is a model for delivering effective, efficient and patient-centered care. The National Committee for Quality Assurance (NCQA) has also set standards for the recognition of medical home status.

- **Use consistent and objective performance measures.** The inclusion of evidence-based measures that have been endorsed by the National Quality Forum (NQF) and adopted by the Hospital Quality Alliance (HQA) helps ensure the consistency and objectivity of the measures adopted.

- **Minimize the data collection burden for providers and insure that all hospitals have an opportunity to participate and succeed.** A VBP program involving smaller facilities, such as Critical Access Hospitals (CAHs), should focus on the hospital outpatient setting as opposed to the inpatient setting as the majority of business for CAHs occurs on the outpatient side. In 2007, total inpatient admissions for Iowa CAHs were 63,000. In contrast, during that same year, the total outpatient visits for Iowa CAHs were just over 3 million. It is also important that policymakers be mindful of the many current demands on providers to report information related to quality.

- **Phased-in approach.** The implementation of a VBP plan should be phased-in over a number of years to allow providers to become comfortable with the measures being used to evaluate the efficiency and quality of care provided.